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(m) Payment rates for the periods January 1, 1986 through December 31, 1986 and January 1, 1987 through December 31, 1987 shall be established on a prospective basis and shall be based on the reimbursable operating costs used in determining payments for services provided during 1985. Such costs shall include the annualized cost impact of rate revisions or adjustments made with respect to such services. The computed rates shall be all-inclusive rates taking into consideration total allowable costs and total inpatient days, except as stated in section 86-1.41 of this Subpart.

(1) Total allowable costs of a facility shall be apportioned among beneficiaries of programs administered under titles XVIII and XIX of the federal Social Security Act and article 43 of the New York State Insurance Law and other patients, so that the share assigned to each program is based upon actual services received by that program's beneficiaries. To accomplish this apportionment, for each program the ratio of beneficiary charges to total patient charges for the services of each ancillary department shall be applied to the cost of the department; to this shall be added the cost of routine services for program beneficiaries, determined on the basis of an average cost per diem. This apportionment shall be based on 1984 data. Hospitals with charge structures from which an apportionment of costs cannot be determined will be paid only on the basis of total average cost per diems, unless the the hospital can provide adequate and verified statistical data to apportion ancillary costs among beneficiaries.

(2) The costs of malpractice insurance premiums and self-insurance fund contributions must be separately accumulated and directly apportioned among programs on the basis of payor experience. Apportionment on the basis of experience shall be based on the dollar ratios for each payor of the facility's malpractice losses paid by that payor to its total paid malpractice losses for the 1984 cost reporting period and the preceding four-year period. If a facility has no malpractice loss experience for the five-year period, the costs of malpractice insurance premiums or self-insurance fund contributions must be apportioned among the programs based on the statewide ratio of malpractice awards paid to program beneficiaries to malpractice awards paid to all patients. If a facility pays allowable uninsured malpractice losses incurred by program beneficiaries, either through allowable deductible or coinsurance provisions, or as a result of an award in excess of reasonable coverage limits, or as a governmental provider, such losses and related direct costs must be directly assigned to a respective program for reimbursement.

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(4) To the allowable basic rates, computed in accordance with ceiling limitations and prior to the addition of a factor for capital costs, there will be added a factor to project allowable cost increases during the effective period of the reimbursement rate. This factor shall be developed in accordance with section 86-1.15 of this Subpart. The allowances specified in subdivisions (p) and (q) of this section shall be computed on the basis of, and added to, the trended basic rate plus capital costs.

(5) Adjustments to rates shall be made to reflect case mix and volume changes and appeals filed and/or adjustments made pursuant to this Subpart.

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